

31A-8-101. Definitions.

For purposes of this chapter:

- (1) "Basic health care services" means:
 - (a) emergency care;
 - (b) inpatient hospital and physician care;
 - (c) outpatient medical services; and
 - (d) out-of-area coverage.
- (2) "Director of health" means:
 - (a) the executive director of the Department of Health; or
 - (b) the authorized representative of the executive director of the Department of Health.
- (3) "Enrollee" means an individual:
 - (a) who has entered into a contract with an organization for health care; or
 - (b) in whose behalf an arrangement for health care has been made.
- (4) "Health care" is as defined in Section 31A-1-301.
- (5) "Health maintenance organization" means any person:
 - (a) other than:
 - (i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or
 - (ii) an individual who contracts to render professional or personal services that the individual directly performs; and
 - (b) that:
 - (i) furnishes at a minimum, either directly or through arrangements with others, basic health care services to an enrollee in return for prepaid periodic payments agreed to in amount prior to the time during which the health care may be furnished; and
 - (ii) is obligated to the enrollee to arrange for or to directly provide available and accessible health care.
- (6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person who furnishes, either directly or through arrangements with others, services:
 - (i) of:
 - (A) dentists;
 - (B) optometrists;
 - (C) physical therapists;
 - (D) podiatrists;
 - (E) psychologists;
 - (F) physicians;
 - (G) chiropractic physicians;
 - (H) naturopathic physicians;
 - (I) osteopathic physicians;
 - (J) social workers;
 - (K) family counselors;
 - (L) other health care providers; or
 - (M) reasonable combinations of the services described in this Subsection
 - (6)(a)(i);
 - (ii) to an enrollee;
 - (iii) in return for prepaid periodic payments agreed to in amount prior to the time

during which the services may be furnished; and

(iv) for which the person is obligated to the enrollee to arrange for or directly provide the available and accessible services described in this Subsection (6)(a).

(b) "Limited health plan" does not include:

(i) a health maintenance organization;

(ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(iii) an individual who contracts to render professional or personal services that the individual performs.

(7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part of the income of which is distributable to its members, trustees, or officers, or a nonprofit cooperative association, except in a manner allowed under Section 31A-8-406.

(b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are used when referring specifically to one of the types of organizations with "nonprofit" status.

(8) "Organization" means a health maintenance organization and limited health plan, unless used in the context of:

(a) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206; or

(b) "organization expenses," which is described in Section 31A-8-208.

(9) "Participating provider" means a provider as defined in Subsection (10) who, under a contract with the health maintenance organization, agrees to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the health maintenance organization, other than copayment.

(10) "Provider" means any person who:

(a) furnishes health care directly to the enrollee; and

(b) is licensed or otherwise authorized to furnish the health care in this state.

(11) "Uncovered expenditures" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the organization's insolvency.

(12) "Unusual or infrequently used health services" means those health services that are projected to involve fewer than 10% of the organization's enrollees' encounters with providers, measured on an annual basis over the organization's entire enrollment.

Amended by Chapter 308, 2002 General Session

31A-8-102. Scope and purposes.

(1) No person may operate an organization in this state without complying with and obtaining a certificate of authority under this chapter.

(2) The purposes of this chapter include to:

(a) provide for the establishment of health maintenance organizations which provide readily available, accessible, and quality comprehensive health care to their enrollees;

(b) provide for the establishment of limited health plans which provide readily available, accessible, and quality care to their enrollees;

(c) encourage the development of organizations as an alternative method of health care delivery; and

(d) assure that organizations offering health plans within this state are financially and administratively sound and that these organizations are in fact able to deliver the benefits as promised.

Enacted by Chapter 204, 1986 General Session

31A-8-103. Applicability to other provisions of law.

(1) (a) Except for exemptions specifically granted under this title, an organization is subject to regulation under all of the provisions of this title.

(b) Notwithstanding any provision of this title, an organization licensed under this chapter:

(i) is wholly exempt from:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations;

(B) Chapter 9, Insurance Fraternal;

(C) Chapter 10, Annuities;

(D) Chapter 11, Motor Clubs;

(E) Chapter 12, State Risk Management Fund;

(F) Chapter 13, Employee Welfare Funds and Plans;

(G) Chapter 19a, Utah Rate Regulation Act; and

(H) Chapter 28, Guaranty Associations; and

(ii) is not subject to:

(A) Chapter 3, Department Funding, Fees, and Taxes, except for Part 1, Funding the Insurance Department;

(B) Section 31A-4-107;

(C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for provisions specifically made applicable by this chapter;

(D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by this chapter;

(E) Chapter 17, Determination of Financial Condition, except:

(I) Part 2, Qualified Assets, and Part 6, Risk-Based Capital; or

(II) as made applicable by the commissioner by rule consistent with this chapter;

(F) Chapter 18, Investments, except as made applicable by the commissioner by rule consistent with this chapter; and

(G) Chapter 22, Contracts in Specific Lines, except for Part 6, Accident and Health Insurance, Part 7, Group Accident and Health Insurance, and Part 12, Reinsurance.

(2) The commissioner may by rule waive other specific provisions of this title that the commissioner considers inapplicable to health maintenance organizations or limited health plans, upon a finding that the waiver will not endanger the interests of:

(a) enrollees;

(b) investors; or

(c) the public.

(3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization

except as specifically made applicable by:

- (a) this chapter;
- (b) a provision referenced under this chapter; or
- (c) a rule adopted by the commissioner to deal with corporate law issues of health maintenance organizations that are not settled under this chapter.

(4) (a) Whenever in this chapter, Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization, the application is:

(i) of those provisions that apply to a mutual corporation if the organization is nonprofit; and

(ii) of those that apply to a stock corporation if the organization is for profit.

(b) When Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization under this chapter, "mutual" means nonprofit organization.

(5) Solicitation of enrollees by an organization is not a violation of any provision of law relating to solicitation or advertising by health professionals if that solicitation is made in accordance with:

(a) this chapter; and

(b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(6) This title does not prohibit any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:

(a) receive federal funds; or

(b) obtain or maintain federal qualification status.

(7) Except as provided in Section 31A-8-501, an organization is exempt from statutes in this title or department rules that restrict or limit the organization's freedom of choice in contracting with or selecting health care providers, including Section 31A-22-618.

(8) An organization is exempt from the assessment or payment of premium taxes imposed by Sections 59-9-101 through 59-9-104.

Amended by Chapter 324, 2010 General Session

31A-8-104. Determination of ability to provide services.

(1) The commissioner may not issue a certificate of authority to an applicant for a certificate of authority under this chapter unless the commissioner has determined that the applicant has:

(a) demonstrated the willingness and potential ability to furnish the proposed health care services in a manner to assure both availability and accessibility of adequate personnel and facilities and continuity of service;

(b) arrangements for an ongoing quality of health care assurance program concerning health care processes and outcomes, established in accordance with rules adopted by the director of the Department of Health based upon prevailing standards for quality assurance for other forms of health care delivery in this state; and

(c) a procedure, established in accordance with rules of the director of the

Department of Health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required by the director of the Department of Health.

(2) Upon receipt of an application for a certificate of authority under this chapter, the commissioner shall transmit a copy of the application and accompanying documents to the director of the Department of Health. Upon receipt of the application, the director of the Department of Health shall review the application, investigate the surrounding facts and circumstances, and make a finding concerning whether the applicant satisfies the requirements of Subsection (1). The director of the Department of Health is considered to have found the applicant to comply with Subsection (1) unless he delivers to the commissioner a finding of noncompliance within 90 days after receiving the application from the commissioner.

(3) In determining whether the requirements of Subsection (1) are satisfied, the commissioner shall rely on the findings of the director of the Department of Health delivered to the commissioner in accordance with Subsection (2).

(4) A finding of noncompliance with Subsection (1) shall specify in what respects the applicant is deficient in meeting the requirements of Subsection (1).

(5) An organization's certificate of authority issued under this chapter is conclusive evidence of compliance with Subsection (1), as to the services authorized to be performed under the certificate of authority, except in a proceeding by the state against the organization. Licensing under this chapter does not exempt an organization from any licensing requirement applicable under Title 26, Chapter 21.

Amended by Chapter 185, 1997 General Session

31A-8-105. General powers of organizations.

Organizations may:

(1) buy, sell, lease, encumber, construct, renovate, operate, or maintain hospitals, health care clinics, other health care facilities, and other real and personal property incidental to and reasonably necessary for the transaction of the business and for the accomplishment of the purposes of the organization;

(2) furnish health care through providers which are under contract with the organization;

(3) contract with insurance companies licensed in this state or with health service corporations authorized to do business in this state for insurance, indemnity, or reimbursement for the cost of health care furnished by the organization;

(4) offer to its enrollees, in addition to health care, insured indemnity benefits, but only for emergency care, out-of-area coverage, unusual or infrequently used health services as defined in Section 31A-8-101, and adoption benefits as provided in Section 31A-22-610.1;

(5) receive from governmental or private agencies payments covering all or part of the cost of the health care furnished by the organization;

(6) lend money to a medical group under contract with it or with a corporation under its control to acquire or construct health care facilities or for other uses to further its program of providing health care services to its enrollees;

(7) be owned jointly by health care professionals and persons not professionally licensed without violating Utah law; and

(8) do all other things necessary for the accomplishment of the purposes of the organization.

Amended by Chapter 329, 1998 General Session

31A-8-105.5. Primary care physicians.

With regard to participating providers who are physicians who are members of the American College of Obstetrics and Gynecology, organizations operating under this chapter shall:

(1) permit a female enrollee to receive at least one outpatient examination per year from the enrollee's choice of one of those participating providers. An organization may not require the enrollee to receive a preapproval, preauthorization, or referral from the enrollee's primary care physician before receiving this examination; and

(2) clearly state in the organization's health benefit plan literature that enrollees may seek the care described in Subsection (1) without preapproval, preauthorization, or referral from the patient's primary care physician.

Amended by Chapter 10, 1997 General Session

31A-8-106. Other business.

No organization may engage, directly or indirectly, in any business other than that of an organization and business reasonably incidental to that business.

Enacted by Chapter 204, 1986 General Session

31A-8-107. Documents as evidence.

Section 31A-5-105 applies to documents as evidence in organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-108. Unauthorized assumption of corporate power.

Section 31A-5-106 applies to the unauthorized assumption of corporate power in organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-201. Scope of part.

This part applies to all organizations doing business in this state.

Amended by Chapter 123, 2005 General Session

31A-8-202. Corporate name -- Office -- Registered agent.

(1) Sections 16-10a-402, 16-10a-403, and 42-2-5 apply to the reservation and registration of the corporate name in domestic health maintenance organizations.

Reservation and registration fees under Section 31A-3-103 apply.

(2) The location of an organization's principal office and the existence of a registered agent are governed by Title 16, Chapter 17, Model Registered Agents Act.

Amended by Chapter 364, 2008 General Session

31A-8-203. Incorporators.

One or more adult natural persons may organize and act as the incorporators of a domestic health maintenance organization under this part.

Enacted by Chapter 204, 1986 General Session

31A-8-204. Articles and bylaws.

(1) The articles of a nonprofit organization shall conform to Subsections 16-6a-202(1)(a) through (e). The articles of other organizations shall conform to Section 16-10a-202. In addition:

(a) the powers of the corporation shall be limited to those permitted under Section 31A-8-105;

(b) the articles shall state whether the organization is a health maintenance organization or a limited health plan;

(c) the articles shall state the services to be provided or for which indemnity is to be paid, which services provided and indemnity guaranteed shall be consistent with the organization's designation under Subsection (1)(b);

(d) the articles shall state that as to health care services for which individual providers are required to be licensed, the services provided by the organization shall be provided by persons properly licensed to perform the services;

(e) the articles shall state whether providers of services are subject to assessment or withholding to pay operating costs or financial deficits;

(f) the articles shall state, for organizations having members, how persons become members and that only members vote; and

(g) the articles of an organization not having members shall state how the directors of the organization shall be selected and removed.

(2) The articles or bylaws shall designate three or more officers as the principal officers of the corporation. The principal offices shall be held by at least three separate natural persons.

(3) Section 31A-5-219 applies to amendments to articles of organizations.

(4) Organizations shall adopt and maintain bylaws. Section 16-6a-206 applies to organizations, except for the statement that bylaws need not be adopted.

Amended by Chapter 364, 2008 General Session

31A-8-205. Organization permit and certificate of incorporation.

(1) Section 31A-5-204 applies to the formation of organizations, except that "Section 31A-5-211" in Subsection 31A-5-204(5) shall be read "Section 31A-8-209."

(2) In addition to the requirements of Section 31A-5-204, the application for a permit shall include a description of the initial locations of facilities where health care

will be available to enrollees, the hours during which various services will be provided, the types of health care personnel to be used at each location and the approximate number of each personnel type to be available at each location, the methods to be used to monitor the quality of health care furnished, the method of resolving adverse benefit determinations initiated by enrollees or providers, the method used to give enrollees an opportunity to participate in matters of policy, the medical records system, and the method for documentation of utilization of health care by persons insured.

Amended by Chapter 308, 2002 General Session

31A-8-206. Powers under organization permit -- Deposit of proceeds of subscriptions.

Sections 31A-5-207 and 31A-5-208 apply to the powers of an organization under an organization permit and the deposit of proceeds of subscriptions, except that there are no qualifying insurance policies as referred to in Subsection 31A-5-207(2)(a).

Enacted by Chapter 204, 1986 General Session

31A-8-207. Termination of organization permit -- Payment of organization expenses.

Section 31A-5-209, other than Subsection 31A-5-209(3)(c), applies to the termination of the organization permit and the payment of organization expenses of organizations, except that "Section 31A-5-212" shall be read "Section 31A-8-213."

Amended by Chapter 185, 2002 General Session

31A-8-208. Incorporators' liability and organization expenses.

Section 31A-5-210 applies to incorporators' liability and organization expenses in organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-209. Minimum capital or minimum permanent surplus.

(1) (a) A health maintenance organization being organized or operating under this chapter shall have and maintain a minimum capital or minimum permanent surplus of \$100,000.

(b) Each health maintenance organization authorized to do business in this state shall have and maintain qualified assets as defined in Subsection 31A-17-201(2) in an amount not less than the total of:

- (i) the health maintenance organization's liabilities;
 - (ii) the health maintenance organization's minimum capital or minimum permanent surplus required by Subsection (1)(a); and
 - (iii) the greater of:
 - (A) the company action level RBC as defined in Subsection 31A-17-601(8)(b); or
 - (B) \$1,300,000.
- (2) (a) The minimum required capital or minimum permanent surplus for a

limited health plan may not:

- (i) be less than \$10,000; or
- (ii) exceed \$100,000.

(b) The initial minimum required capital or minimum permanent surplus for a limited health plan required by Subsection (2)(a) shall be set by the commissioner, after:

- (i) a hearing; and
- (ii) consideration of:
 - (A) the services to be provided by the limited health plan;
 - (B) the size and geographical distribution of the population the limited health plan anticipates serving;
 - (C) the nature of the limited health plan's arrangements with providers; and
 - (D) the arrangements, agreements, and relationships of the limited health plan in place or reasonably anticipated with respect to:

(I) insolvency insurance;

(II) reinsurance;

(III) lenders subordinating to the interests of enrollees and trade creditors;

(IV) personal and corporate financial guarantees;

(V) provider withholds and assessments;

(VI) surety bonds;

(VII) hold harmless agreements in provider contracts; and

(VIII) other arrangements, agreements, and relationships impacting the security of enrollees.

(c) Upon a material change in the scope or nature of a limited health plan's operations, the commissioner may, after a hearing, alter the limited health plan's minimum required capital or minimum permanent surplus.

(3) The commissioner may allow the minimum capital or permanent surplus account of an organization to be designated by some other name.

(4) A pattern of persistent deviation from the accounting and investment standards under this section may be grounds for the commissioner to find that the one or more persons with authority to make the organization's accounting or investment decisions are incompetent for purposes of Subsection 31A-5-410(3).

Amended by Chapter 308, 2002 General Session

31A-8-211. Deposit.

(1) Except as provided in Subsection (2), each health maintenance organization authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the sum of:

- (a) \$100,000; and
- (b) 50% of the greater of:
 - (i) \$900,000;
 - (ii) 2% of the annual premium revenues as reported on the most recent annual financial statement filed with the commissioner; or
 - (iii) an amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the

commissioner.

(2) (a) After a hearing the commissioner may exempt a health maintenance organization from the deposit requirement of Subsection (1) if:

(i) the commissioner determines that the enrollees' interests are adequately protected;

(ii) the health maintenance organization has been continuously authorized to do business in this state for at least five years; and

(iii) the health maintenance organization has \$5,000,000 surplus in excess of the health maintenance organization's company action level RBC as defined in Subsection 31A-17-601(8)(b).

(b) The commissioner may rescind an exemption given under Subsection (2)(a).

(3) (a) Each limited health plan authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the minimum capital or permanent surplus plus 50% of the greater of:

(i) .5 times minimum required capital or minimum permanent surplus; or

(ii) (A) during the first year of operation, 10% of the limited health plan's projected uncovered expenditures for the first year of operation;

(B) during the second year of operation, 12% of the limited health plan's projected uncovered expenditures for the second year of operation;

(C) during the third year of operation, 14% of the limited health plan's projected uncovered expenditures for the third year of operation;

(D) during the fourth year of operation, 18% of the limited health plan's projected uncovered expenditures during the fourth year of operation; or

(E) during the fifth year of operation, and during all subsequent years, 20% of the limited health plan's projected uncovered expenditures for the previous 12 months.

(b) Projections of future uncovered expenditures shall be established in a manner that is approved by the commissioner.

(4) A deposit required by this section may be counted toward the minimum capital or minimum permanent surplus required under Section 31A-8-209.

Amended by Chapter 308, 2002 General Session

31A-8-213. Certificate of authority.

(1) An organization may apply for a certificate of authority at any time prior to the expiration of its organization permit. The application shall include:

(a) a detailed statement by a principal officer about any material changes that have taken place or are likely to take place in the facts on which the issuance of the organization permit was based; and

(b) if any material changes are proposed in the business plan, the information about the changes that would be required if an organization permit were then being applied for.

(2) The commissioner shall issue a certificate of authority, if the commissioner finds that:

(a) the organization's capital and surplus complies with the requirements of Section 31A-8-209 as to the operations proposed under the new certificate of authority;

(b) there is no basis for revoking the organization permit under Section

31A-8-207;

- (c) the deposit required by Section 31A-8-211 has been made;
- (d) the organization satisfies the requirements of Section 31A-8-104; and
- (e) all other applicable requirements of the law have been met.

(3) The certificate of authority shall specify any limits imposed by the commissioner upon the organization's business or methods of operation, including the general types of health care services the organization is authorized to provide.

(4) Upon the issuance of the certificate of authority:

(a) the board shall authorize and direct the issuance of certificates for shares, bonds, or notes subscribed to under the organization permit, and of insurance policies upon qualifying applications obtained under the organization permit; and

(b) the commissioner shall authorize the release to the organization of all funds held in escrow under Section 31A-5-208, as adopted by Section 31A-8-206.

(5) (a) An organization may at any time apply to the commissioner for a new or amended certificate of authority altering the limits on its business or methods of operation. The application shall contain or be accompanied by that information reasonably required by the commissioner under Subsections 31A-5-204(2) and 31A-8-205(2). The commissioner shall issue the new certificate as requested if the commissioner finds that the organization continues to satisfy the requirements specified under Subsection (2).

(b) If the commissioner issues an order under Chapter 27, Part 5, Administration Actions, against an organization, the commissioner may also revoke the organization's certificate and issue a new one with any limitation the commissioner considers necessary.

Amended by Chapter 309, 2007 General Session

31A-8-214. Securities.

Chapter 5, Part 3, Securities of Domestic Insurance Corporations, applies to securities of organizations, except that the amount "\$150,000" in Subsection 31A-5-304(1) shall be read "one-half of the minimum capital required of the organization."

Amended by Chapter 90, 2004 General Session

31A-8-215. Management.

Chapter 5, Part 4, Management of Insurance Corporations, applies to organizations, except that for purposes of this chapter, Subsections 31A-5-412(3)(a)(vi) through (ix) shall be read: "corporate reorganizations under Section 31A-8-216."

Amended by Chapter 349, 2009 General Session

31A-8-216. Corporate reorganizations.

Sections 31A-5-501 through 31A-5-506 and Section 31A-5-508 apply to corporate reorganizations of organizations.

Enacted by Chapter 204, 1986 General Session

31A-8-217. Material transactions by insurers which are part of holding company system.

(1) This section applies to an insurer licensed under this chapter that is part of a holding company system, for purposes of:

- (a) the reporting requirements of Section 31A-16-105; and
- (b) the material transaction standards of Section 31A-16-106.

(2) Unless otherwise provided by rule, a transaction is not material under Subsection 31A-16-105(4) if the transaction involves an amount:

- (a) of not more than:
 - (i) 10% for each transaction; or
 - (ii) 20% for cumulative transactions during any one calendar year; and
- (b) calculated:
 - (i) on the basis of the organization's surplus requirement, determined in accordance with Section 31A-5-211; and
 - (ii) as of December 31 of the year immediately preceding the transaction.

Amended by Chapter 252, 2003 General Session

31A-8-301. Requirements for doing business in state.

(1) Only a corporation incorporated and licensed under Part 2, Domestic Organizations, may do business in this state as an organization.

(2) To do business in this state as an organization, a foreign corporation doing a similar business in other states shall incorporate a subsidiary and license it under Part 2, Domestic Organizations, for its Utah business. Except as to Chapter 16, Insurance Holding Companies, the laws applicable to a domestic organization apply only to the domestic organization and not to its foreign parent corporation.

Amended by Chapter 319, 2013 General Session

31A-8-401. Enrollee participation.

Every organization shall provide a reasonable procedure, consistent with Section 31A-4-116, for allowing enrollees to participate in matters of policy of the organization and for resolving complaints and adverse benefit determinations initiated by enrollees or providers.

Amended by Chapter 308, 2002 General Session

31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit plans.

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

- (a) with respect to all eligible employees and dependents; and
- (b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed

for a network plan, if:

(a) there is no longer any enrollee under the group health plan who lives, resides, or works in:

- (i) the service area of the insurer; or
- (ii) the area for which the insurer is authorized to do business; or

(b) for coverage made available in the small or large employer market only through an association, if:

- (i) the employer's membership in the association ceases; and
- (ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A health benefit plan for a plan sponsor may be discontinued if:

- (a) a condition described in Subsection (2) exists;
- (b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;
- (c) the plan sponsor:
 - (i) performs an act or practice that constitutes fraud; or
 - (ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
- (d) the insurer:
 - (i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and
 - (ii) (A) provides notice of the discontinuation in writing:
 - (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
 - (II) at least 90 days before the date the coverage will be discontinued;
 - (B) provides notice of the discontinuation in writing:
 - (I) to the commissioner; and
 - (II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;
 - (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
 - (I) all other health benefit products currently being offered by the insurer in the market; or
 - (II) in the case of a large employer, any other health benefit product currently being offered in that market; and
 - (D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:
 - (I) the claims experience of a plan sponsor;
 - (II) any health status-related factor relating to any covered participant or beneficiary; or
 - (III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or
- (e) the insurer:
 - (i) elects to discontinue all of the insurer's health benefit plans in:
 - (A) the small employer market;
 - (B) the large employer market; or

- (C) both the small employer and large employer markets; and
- (ii) (A) provides notice of the discontinuation in writing:
 - (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
 - (II) at least 180 days before the date the coverage will be discontinued;
- (B) provides notice of the discontinuation in writing:
 - (I) to the commissioner in each state in which an affected insured individual is known to reside; and
 - (II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;
- (C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and
- (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
- (4) A large employer health benefit plan may be discontinued or nonrenewed:
 - (a) if a condition described in Subsection (2) exists; or
 - (b) for noncompliance with the insurer's:
 - (i) minimum participation requirements; or
 - (ii) employer contribution requirements.
- (5) A small employer health benefit plan may be discontinued or nonrenewed:
 - (a) if a condition described in Subsection (2) exists; or
 - (b) for noncompliance with the insurer's employer contribution requirements.
- (6) A small employer health benefit plan may be nonrenewed:
 - (a) if a condition described in Subsection (2) exists; or
 - (b) for noncompliance with the insurer's minimum participation requirements.
- (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:
 - (i) engages in an act or practice in connection with the coverage that constitutes fraud; or
 - (ii) makes an intentional misrepresentation of material fact in connection with the coverage.
- (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
 - (i) 12 months after the date of discontinuance; and
 - (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.
- (c) At the time the eligible employee's coverage is discontinued under Subsection (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.
- (d) An eligible employee may not be discontinued under this Subsection (7) because of a fraud or misrepresentation that relates to health status.
- (8) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:
 - (a) with respect to coverage provided to an employer member of the association; and
 - (b) if the health benefit plan is made available by an insurer in the employer market only through:

- (i) an association;
- (ii) a trust; or
- (iii) a discretionary group.
- (9) An insurer may modify a health benefit plan for a plan sponsor only:
 - (a) at the time of coverage renewal; and
 - (b) if the modification is effective uniformly among all plans with that product.

Amended by Chapter 290, 2014 General Session
 Amended by Chapter 300, 2014 General Session
 Amended by Chapter 425, 2014 General Session

31A-8-402.5. Individual discontinuance and nonrenewal.

- (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:
 - (i) with respect to all individuals or dependents; and
 - (ii) at the option of the individual.
- (b) Subsection (1)(a) applies regardless of:
 - (i) whether the contract is issued through:
 - (A) a trust;
 - (B) an association;
 - (C) a discretionary group; or
 - (D) other similar grouping; or
 - (ii) the situs of delivery of the policy or contract.
- (2) A health benefit plan may be discontinued or nonrenewed:
 - (a) for a network plan, if:
 - (i) the individual no longer lives, resides, or works in:
 - (A) the service area of the insurer; or
 - (B) the area for which the insurer is authorized to do business; and
 - (ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or
 - (b) for coverage made available through an association, if:
 - (i) the individual's membership in the association ceases; and
 - (ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.
- (3) A health benefit plan may be discontinued if:
 - (a) a condition described in Subsection (2) exists;
 - (b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;
 - (c) the individual:
 - (i) performs an act or practice in connection with the coverage that constitutes fraud; or
 - (ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
 - (d) the insurer:
 - (i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and

- (ii) (A) provides notice of the discontinuation in writing:
 - (I) to each individual provided coverage; and
 - (II) at least 90 days before the date the coverage will be discontinued;
- (B) provides notice of the discontinuation in writing:
 - (I) to the commissioner; and
 - (II) at least three working days prior to the date the notice is sent to the affected individuals;
- (C) offers to each covered individual on a guaranteed issue basis, the option to purchase all other individual health benefit products currently being offered by the insurer for individuals in that market; and
- (D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage; or
- (e) the insurer:
 - (i) elects to discontinue all of the insurer's health benefit plans in the individual market; and
 - (ii) (A) provides notice of the discontinuation in writing:
 - (I) to each individual provided coverage; and
 - (II) at least 180 days before the date the coverage will be discontinued;
 - (B) provides notice of the discontinuation in writing:
 - (I) to the commissioner in each state in which an affected insured individual is known to reside; and
 - (II) at least 30 working days prior to the date the notice is sent to the affected individuals;
 - (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for issuance in the individual market; and
 - (D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

Amended by Chapter 252, 2003 General Session

31A-8-402.7. Discontinuance and nonrenewal limitations.

- (1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under Subsections 31A-8-402.3(3)(e) and 31A-8-402.5(3)(e) is prohibited from writing new business:
 - (a) in the market in this state for which the insurer discontinues or does not renew; and
 - (b) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.
- (2) If an insurer is doing business in one established geographic service area of the state, Sections 31A-8-402.3 and 31A-8-402.5 apply only to the insurer's operations in that service area.
- (3) The commissioner may, by rule or order, define the scope of service area.

Amended by Chapter 78, 2005 General Session

31A-8-403. Examination of organization and providers.

Examinations of a health maintenance organization and its providers shall be conducted according to the provisions of Chapter 2. Except during an audit of the internal quality control system, medical records of individual patients kept by the organization or its providers are not subject to examination.

Enacted by Chapter 204, 1986 General Session

31A-8-404. Annual audit of internal quality control.

Each organization shall prepare an annual report of the effectiveness of the organization's internal quality control. The report shall be in a form prescribed by the commissioner after consultation with the director of the Department of Health, and shall be certified and signed by two officers of the organization. The commissioner may at any time require an audit of an organization's quality control system. The audit shall be performed by qualified persons designated by the commissioner. Auditors shall have full access to all records of the organization and its providers, including medical records of individual patients. The information contained in the medical records of individual patients shall remain confidential, and information derived from those records may not be used in a manner that could directly or indirectly identify an individual. All information, interviews, reports, statements, memoranda, or other data furnished by reason of the audit and any findings or conclusions of the auditors are privileged and are not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner or the director of the Department of Health concerning alleged violations of the provisions of this chapter.

Amended by Chapter 314, 1994 General Session

31A-8-405. Confidentiality of medical records and audits.

Unless a court orders otherwise, the department shall treat the following records and information as confidential and prevent their disclosure to the public:

- (1) the medical records of enrollees of an organization; and
- (2) the annual audits performed under Section 31A-8-404.

Enacted by Chapter 204, 1986 General Session

31A-8-406. Distribution by nonprofit organizations.

A nonprofit organization may pay compensation in a reasonable amount to its members, trustees, or officers for services rendered, may make reasonable incentive payments to its providers, may confer benefits upon its members in conformity with its purposes, may pay interest on certificates of indebtedness issued by it evidencing capital contributions, and upon dissolution or final liquidation may make distributions to its members as permitted by Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and no such payment, benefit, or distribution shall be considered to be a dividend or distribution of income. Notwithstanding Section 31A-8-105, and in addition to the powers granted in that section, a nonprofit organization has all powers conferred upon it by Section 16-6a-302.

Amended by Chapter 300, 2000 General Session

31A-8-407. Written contracts -- Limited liability of enrollee -- Provider claim disputes -- Leased networks.

(1) (a) Every contract between an organization and a participating provider of health care services shall be in writing and shall set forth that if the organization:

(i) fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the organization; and

(ii) becomes insolvent, the rehabilitator or liquidator may require the participating provider of health care services to:

(A) continue to provide health care services under the contract between the participating provider and the organization until the earlier of:

(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise entitled to receive from the organization under the contract between the participating provider and the organization during the time period described in Subsection (1)(a)(ii)(A).

(b) If the conditions of Subsection (1)(c) are met, the participating provider shall:

(i) accept the reduced payment as payment in full; and

(ii) relinquish the right to collect additional amounts from the insolvent organization's enrollee.

(c) Notwithstanding Subsection (1)(a)(ii)(B):

(i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the participating provider contract; and

(ii) the enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the participating provider that the enrollee was required to pay before the filing of:

(A) the petition for rehabilitation; or

(B) the petition for liquidation.

(2) A participating provider may not collect or attempt to collect from the enrollee sums owed by the organization or the amount of the regular fee reduction authorized under Subsection (1)(a)(ii) if the participating provider contract:

(a) is not in writing as required in Subsection (1); or

(b) fails to contain the language required by Subsection (1).

(3) (a) A person listed in Subsection (3)(b) may not bill or maintain any action at law against an enrollee to collect:

(i) sums owed by the organization; or

(ii) the amount of the regular fee reduction authorized under Subsection (1)(a)(ii).

(b) Subsection (3)(a) applies to:

(i) a participating provider;

(ii) an agent;

(iii) a trustee; or

(iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).

(c) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the organization's written payment policies in effect at the time services were rendered.

(d) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (3)(d) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(e) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(4) If an organization permits another private entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks that include participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network unless payment for services is governed by a public program's fee schedule.

Amended by Chapter 3, 2005 Special Session 1

31A-8-408. Organizations offering point of service or point of sales products.

Effective July 1, 1991, a health maintenance organization offering products that permit members the option of obtaining covered services from a noncontracted provider, which is a point of service or point of sale product, shall comply with the requirements of Subsections (1) through (7).

(1) The cost of an encounter with a noncontracted provider is considered an uncovered expenditure as defined in Section 31A-8-101.

(2) (a) An organization shall report to the commissioner on a monthly basis the number of encounters with contracted and noncontracted providers if the organization offers to sell a:

(i) point of service product; or

(ii) point of sale product.

(b) The commissioner shall:

(i) define the form, content, and due date of the report required by this Subsection (2); and

(ii) require audited reports of the information on a yearly basis.

(3) An organization may not offer a point of service product or a point of sale product unless the organization has secured contracts with participating providers located within the organization's service area for each covered service other than those unusual or infrequently used health services that are not available from the organization's health care providers.

(4) An organization may not enroll a member who does not work or reside in the service area as defined by rule, except this Subsection (4) does not apply to a dependent of an enrollee.

(5) Any organization that exceeds the 10% limit of unusual or infrequently used health services as defined in Section 31A-8-101 is subject to a forfeiture of up to \$50 per encounter.

(6) An organization shall disclose to employees and members the existence of the 10% limit:

- (a) at enrollment; or
- (b) prior to enrollment.

(7) The commissioner shall hold hearings and adopt rules providing any additional limitations or requirements necessary to secure the public interest in conformity with this section.

Amended by Chapter 308, 2002 General Session

31A-8-501. Access to health care providers.

(1) As used in this section:

(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(b) "Covered health care services" or "covered services" means health care services for which an enrollee is entitled to receive under the terms of a health maintenance organization contract.

(c) "Credentialed staff member" means a health care provider with active staff privileges at an independent hospital or federally qualified health center.

(d) "Federally qualified health center" means as defined in the Social Security Act, 42 U.S.C. Sec. 1395x.

(e) "Independent hospital" means a general acute hospital or a critical access hospital that:

(i) is either:

(A) located 20 miles or more from any other general acute hospital or critical access hospital; or

(B) licensed as of January 1, 2004;

(ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and

(iii) is controlled by a board of directors of which 51% or more reside in the county where the hospital is located and:

(A) the board of directors is ultimately responsible for the policy and financial decisions of the hospital; or

(B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part, by an entity that owns or controls a health maintenance organization if the hospital is a contracting facility of the organization.

(f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member who has not contracted with a health maintenance organization to provide health care services to enrollees of the organization.

(2) Except for a health maintenance organization which is under the common ownership or control of an entity with a hospital located within 10 paved road miles of an independent hospital, a health maintenance organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the independent hospital; or

(ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the independent hospital than a contracting hospital;

(b) the independent hospital is located prior to December 31, 2000 in a county with a population density of less than 100 people per square mile, or the independent hospital is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(3) A health maintenance organization shall pay for covered health care services rendered to an enrollee at a federally qualified health center if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the federally qualified health center; or

(ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the federally qualified health center than a contracting provider;

(b) the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(4) (a) A health maintenance organization shall reimburse a noncontracting provider or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as it pays to contracting providers under a noncapitated arrangement for comparable services.

(b) A health maintenance organization shall reimburse a federally qualified health center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by the health maintenance organization under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service.

(5) (a) A noncontracting independent hospital may not balance bill a patient when the health maintenance organization reimburses a noncontracting independent hospital or an enrollee in accordance with Subsection (4)(a).

(b) A noncontracting federally qualified health center may not balance bill a patient when the federally qualified health center or the enrollee receives reimbursement in accordance with Subsection (4)(b).

(6) A noncontracting provider may only refer an enrollee to another noncontracting provider so as to obligate the enrollee's health maintenance organization to pay for the resulting services if:

(a) the noncontracting provider making the referral or the enrollee has received

prior authorization from the organization for the referral; or

(b) the practice location of the noncontracting provider to whom the referral is made:

(i) is located in a county with a population density of less than 25 people per square mile; and

(ii) is within 30 paved road miles of:

(A) the place where the enrollee lives or resides; or

(B) the independent hospital or federally qualified health center at which the enrollee may receive covered services pursuant to Subsection (2) or (3).

(7) Notwithstanding this section, a health maintenance organization may contract directly with an independent hospital, federally qualified health center, or credentialed staff member.

(8) (a) A health maintenance organization that violates any provision of this section is subject to sanctions as determined by the commissioner in accordance with Section 31A-2-308.

(b) Violations of this section include:

(i) failing to provide the notice required by Subsection (8)(d) by placing the notice in any health maintenance organization's provider list that is supplied to enrollees, including any website maintained by the health maintenance organization;

(ii) failing to provide notice of an enrollee's rights under this section when:

(A) an enrollee makes personal contact with the health maintenance organization by telephone, electronic transaction, or in person; and

(B) the enrollee inquires about his rights to access an independent hospital or federally qualified health center; and

(iii) refusing to reprocess or reconsider a claim, initially denied by the health maintenance organization, when the provisions of this section apply to the claim.

(c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner:

(i) adopt rules as necessary to implement this section;

(ii) identify in rule:

(A) the counties with a population density of less than 100 people per square mile;

(B) independent hospitals as defined in Subsection (1)(e); and

(C) federally qualified health centers as defined in Subsection (1)(d).

(d) (i) A health maintenance organization shall:

(A) use the information developed by the commissioner under Subsection (8)(c) to identify the rural counties, independent hospitals, and federally qualified health centers that are located in the health maintenance organization's service area; and

(B) include the providers identified under Subsection (8)(d)(i)(A) in the notice required in Subsection (8)(d)(ii).

(ii) The health maintenance organization shall provide the following notice, in bold type, to enrollees as specified under Subsection (8)(b)(i), and shall keep the notice current:

"You may be entitled to coverage for health care services from the following non-HMO contracted providers if you live or reside within 30 paved road miles of the listed providers, or if you live or reside in closer proximity to the listed providers than to

your HMO contracted providers:

This list may change periodically, please check on our website or call for verification. Please be advised that if you choose a noncontracted provider you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a provider on this list you may contact your health maintenance organization at _____. If the HMO does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free."

(e) A person whose interests are affected by an alleged violation of this section may contact the Office of Consumer Health Assistance and request assistance, or file a complaint as provided in Section 31A-2-216.

Amended by Chapter 369, 2012 General Session

31A-8-502. Court ordered coverage for minor children who reside outside the service area.

(1) (a) The requirements of Subsection (2) apply to a health maintenance organization if the health maintenance organization plan:

(i) restricts coverage for nonemergency services to services provided by contracted providers within the organization's service area; and

(ii) does not offer a benefit that permits members the option of obtaining covered services from a non-contracted provider.

(b) The requirements of Subsection (2) do not apply to a health maintenance organization if:

(i) the child that is the subject of a court or administrative support order is over the age of 18 and is no longer enrolled in high school; or

(ii) a parent's employer offers the parent a choice to select health insurance coverage that is not a health maintenance organization plan either at the time of the court or administrative support order, or at a subsequent open enrollment period. This exemption from Subsection (2) applies even if the parent ultimately chooses the health maintenance organization plan.

(2) If a parent is required by a court or administrative support order to provide health insurance coverage for a child who resides outside of a health maintenance organization's service area, the health maintenance organization shall:

(a) comply with the provisions of Section 31A-22-610.5;

(b) allow the enrollee parent to enroll the child on the organization plan;

(c) pay for otherwise covered health care services rendered to the child outside of the service area by a noncontracted provider:

(i) if the child, noncustodial parent, or custodial parent has complied with prior authorization or utilization review otherwise required by the organization; and

(ii) in an amount equal to the dollar amount the organization pays under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the services; and

(d) make payments on claims submitted in accordance with Subsection (2)(c) directly to the provider, custodial parent, the child who obtained benefits, or state Medicaid agency.

(3) (a) The parents of the child who is the subject of the court or administrative support order are responsible for any charges billed by the provider in excess of those paid by the organization.

(b) This section does not affect any court or administrative order regarding the responsibilities between the parents to pay any medical expenses not covered by accident and health insurance or a health maintenance organization plan.

(4) The commissioner shall adopt rules as necessary to administer this section and Section 31A-22-610.5.

Enacted by Chapter 178, 2004 General Session